CASE REPORT

A case of Sacroilitis with Polyarthritis

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Summary

Evidence based case record of a twenty two year old girl treated for Polyarthritis at Regional Research Institute for Homoeopathy, New Shimla. When conventional therapy failed to bring about any relief, Homoeopathic treatment brought about dramatic relief and cured the patient. Not only there was complete regression of clinical signs and symptoms but haemato-serological readings too came down to normal, within physiological range.

Introduction

Polyarthritis is involvement of five or more joints or joint groups. In determining the case it is helpful to consider whether the polyathritis:

- Is symmetrical (approximately) or asymmetrical
- Shows predominant or equal involvement for upper and lower limbs
- Shows predominant or equal involvement for large and small joints
- Has accompanying periarticular or extra-articular features as clues to the diagnosis

A large number of viral infections may cause arthralgia and rapid onset of an acute symmetrical inflammatory polyarthritis affecting small and large joints of upper and lower limbs that is usually self limiting within 6 weeks.

Polyarthritis that persists for more than 6 weeks is unlikely to be viral. A definitive diagnosis may be difficult in the first few months of onset but often becomes firmer as more characteristic features develop with time. However, certain patterns are characteristic and may be present at or soon after presentation. Rheumatoid arthritis is by far the most common cause of chronic inflammatory, symmetrical polyarthritis affecting small and large joints of upper and lower limbs. Marked asymmetry, lower limb predominance and involvement of large more than small joints are all more characteristic of seronegative spondarthritis.

Case Report

A 22 year old girl, student B.A. Part III, almost confined to bed due to pain in left hip region and other large joints of upper and lower limbs. She was investigated at Indira Gandhi Medical College and Associated Hospitals, Shimla. Later on at Sir Ganga Ram Hospital, New Delhi. She got MRI left hip region done at Diwan Chand Satya Pal Aggarwal Imaging Research Centre, New Delhi.

Following were the reports of various haematoserological tests and MR Imaging done between 17th and 29th May:

- ESR...........................50 mm in 1st hr.
- Haemoglobin.......10 gm %
- CRP..........................Reactive, 3.91mg/dL (Normal non-reactive and value < 0.6)
- RA-factor.................Negative
- ASO.........................66.00 IU/mL WNR

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- Uric acid............4.23 mg/dL WNR
- Calcium...............9.74 mg/dL WNR
- MRI..........................MR scan findings are suggestive of left sided sacroilitis with mild Joint effusion and adjacent myofascial oedema.

She was treated at above hospitals from 17.05. to 20.06.2006. She was prescribed NSAIDs (Non-steroid anti-inflammatory drugs) and HCQS (Hydroxy chloroquin sulphate). But to no avail. She was also prescribed inj. Penidura LA 12 Lac. But the patient refused to take penicillin injection.

At this stage the patient reported at RRI, New Shimla on 23.06.06 for Homoeopathic treatment. After perusal of her case records and on interrogation symptoms gathered for analysis of the case were:

i. Pain in various joints, mainly large joints of upper and lower limbs, since April
ii. Involvement of these joints was asymmetrical and accompanied with heat and swelling
iii. Pain in lower back but the severity was most experienced in left gluteal/hip region < on movement, pressure, and was unable to sit or stand due to excruciating pain
iv. Unableto turn side or lie on back or left side (painful side). She could lie only on right side with relief
v. Hot fomentation gave some relief
vi. She was highly chilly not only during her disease but otherwise also. This was evident from the fact that she would wear sweater even during summer in Shimla and she did not like to have cooler or AC on in Delhi during her stay there for various investigations in the month of May. She did not like winter season.
vii. She had a consistent time modality from day one and that was aggravation of pains between 3-4 am. She would wake up with severe pain between 3 to 4 am.

Past history

Except pneumonia at the age of 12 years, she did not suffer from any other significant ailment. For pneumonia she was given allopathic treatment.

Family history

Nothing significant could be elicited.

Menstrual history

Menarche at the age of 15 years. Menstrual cycle more or less normal, painless.

Physical generalities

Build - Average
Thermal reaction - Highly chilly
Appetite - Good
Thirst - Normal, but avoids cold water
Sweat - Moderate perspiration as evident from cold but moist palms and soles.

Mind

Irritability, sensitive and anxiety prone.

On clinical examination

Pallor+
No cyanosis, no clubbing of nails, no lymphadenopathy
Pulse - tachycardia 90/minute
B.P. - Normotensive 110/76mm of Hg.

CVS - NAD
GIS & Resp. Sys - NAD
Local examination of joints - swollen, pale, hot, tender

Treatment: after careful perusal and analysis of the symptoms treatment given was as under:

23.06.2006
Kali carb. 30 TDS for 5 *days,* patient was advised to stop the medicine as soon as she experiences any improvement in pain.

30.06.2006
Patient narrated that on 4th day of starting the medicine she experienced some relief in pain as she did not have to get up early in the morning due to pain. And this had happened for the first time in the past 2 and a half months. Then she stopped the medicine. But this morning she again had the pain.

Kali carb. 30 TDS for 5 days with same piece of advice.

14.07.2006
Patient was very happy and narrated that she took the medicine for 5 days and thereafter did not require. Now she can very well change sides in the bed and can move around with little distress. But this morning she experienced mild pain and was forced to lie on right side. While she was reporting, apprehension was quite evident on her face that she might get the same pain again. She was reassured with a little advice on food and other lifestyle.

Kali carb. 200 three doses to be taken TDS for one day only.
Placebo BD for 15 days.

19.08.2006
Patient reporting after more than one month itself shows that she is no more distressed by her ailment and so did she report. But occasionally she experienced pain in calf region on walking.

Kali carb. 200 three doses to be taken TDS for one day only.
Placebo BD for 15 days.

16.09.2006
No pain in lower back and hip region or any other joint. But some discomfort is experienced in calf muscles on walking which was decidedly less than what she complained last time.

Placebo BD for 4 days.

22.09.2006

Patient is almost asymptomatic.

Placebo OD for 15 days.
Also advised to get CRP and ESR done once again.

12.10.2006
Patient reported completely asymptomatic. There was no pain or any other complaint left. She brought the test reports which she got done on 10th October.
CRP..................Non reactive i.e. < 0.6 mg/dL (it has come down from 3.91mg/dL)
ESR..................20mm in 1st hr. (earlier it was 50mm)
Hb...................11gm% (earlier it was 10gm %)
MRI being a costly test, the patient expressed her inability to get it done, more so when there was no problem left.
Kali carb 1M one dose. With this dose the treatment was concluded. However, the patient was advised to report in case of any recurrence.

Discussion

In this case polyarthritis persisted for more than 6 weeks. Hence, it is unlikely to be of viral origin (self limiting). When the patient came to us it was already over 10 weeks. Asymmetrical involvement of large joints with predominance of lower limb joints, negative Rheumatoid factor, normal uric acid level go in favour of seronegatve spondarthritis.

The simillimum was selected keeping in view the outstanding time-modality which persisted from day one. This was such an outstanding characteristic/peculiar modality which alone sufficed individualize the patient and none other than Kali carb could have been thought of. The other symptoms too fell in line in favour of Kali carb.

> *M.L. Tyler writes, "Pains stitching, darting < during rest and lying on affected side. She could not lie on left side that is affected side. Could lie only on right side."*
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> *In Allen's Encyclopedia it is mentioned, "lumbago with sudden sharp lancinating pains extending up and down the back, rarely through to the front, the patient is attacked at 3 AM and cannot remain in bed. Lumbago, as if the small of back were broken, pains shooting back of thighs."*

Thus, Kali carb. not only brought about complete regression of clinical symptoms and signs but also helped bring down elevated levels of CRP and ESR from 3.91 to < 0.6mg/dL and 50 to 20 mm in 1st hr. respectively. Anaemia too improved as evident from rise in Hb level from 10 to 11gm%

References

1. *Davidson's Principles and Practice of Medicine* pages 975-977.
2. *Journal of Association of Physicians of India* (JAPI) Vol.40, March-1992, for case presentation format.
3. *Allen's Encyclopedia* page 603.
4. *CCRH Quarterly Bulletin*, Vol. 27, No. 4, for case presentation format.
5. *Synthesis* (Repertorium Homeopathicum Syntheticum) Back - Pain - night - midnight after - 3 h.
6. *Homoeopathic Drug Pictures* by M.L. Tyler pages 473-74.